The solitary confinement of incarcerated American youth during COVID-19

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Letter to the Editor

The solitary confinement of incarcerated American youth during COVID-19

Dear editor,

In spring 2020, various states of emergency, stay-at-home orders, and school closures were enacted due to COVID-19. Since then, American juvenile correctional facilities (JCFs) have faced a complex situation that requires consideration of staff and youth safety and physical health, the need for social distancing, and the high prevalence of youth with mental disorders. While youth are typically at low risk from COVID-19 complications, incarcerated youth have more physical health disorders (e.g., asthma, diabetes) than youth in the community (Winkelman et al., 2017). Moreover, Winkelman and colleagues reported that African-American youth, a group that is overrepresented in the JC system, have higher incidence of physical health disorders than incarcerated Caucasian youth. As such, critical adherence to safety measures and social distancing within a facility are even greater than in the community.

The risk of COVID-19 in JCFs is concerning and although information is seriously limited, in April 2020, 1 in 6 cases in Louisiana were in JCFs (Sparks, 2020). However, only anecdotal information exists concerning JCFs approaches to the physical safety of youth. Reports indicate staff and youth are required to wear masks in some facilities, while it is forbidden in others due to security concerns (Council of Juvenile Justice and Administrators (CJJA), 2020). Additionally, overcrowding and limitations in space likely result in youth isolation in their individual cells. As such, isolation typically consists of a youth staying in a cell measuring about 6 × 8 feet for 23 h per day with an almost complete lack of human contact (Sparks, 2020). At best, a youth may talk with a mental health professional or teacher through the door for a couple minutes per day. Despite the difference in intent from punitive solitary confinement, COVID-19-related social isolation for incarcerated youth is nonetheless, tantamount to solitary confinement. It is important to note that the United Nations' Convention on the Rights of the Child and the abolishment of juvenile solitary confinement included therein, has been ratified by every country except the United States.

Even for people in the community during COVID-19, social isolation can be a traumatic experience that can result in loneliness, depression, anxiety, and make it more difficult to deal with stress. The psychological effects of solitary confinement for incarcerated youth are even more dramatic and may include depression, anger, obsessive thoughts, paranoia and psychosis, and suicide (Simkins et al., 2014). Any decisions to impose such dramatic isolation on incarcerated youth must take into consideration their already fragile state, with 70% having a pre-existing mental disorder (e.g., conduct disorder, anxiety, depression; Shufelt and Cocozza, 2006). Moreover, 95% of youth have experienced trauma (Becker and Kerig, 2011). Youth with pre-existing mental disorders and with the special education classification of emotional disturbance, another overrepresented group in JC, can experience more pronounced effects from solitary confinement (Dierkhising et al., 2013).

In addition to solitary confinement, the reduced access to familial contact can further exacerbate youth mental health problems. By early April, all 50 states had suspended in-person visits to JCFs (CJJA, 2020). Beyond state and facility regulations, the ability of families to travel to the JCF in which their child is incarcerated have also been hampered by state lockdowns and social distance policies. Frequent contact with families have the potential to reduce youth anxiety and depression, as well as problem behavior. Information concerning adaptations made by specific JCFs to increase phone or video contacts between youth and families is seriously limited. Anecdotally, one facility reported allowing daily contact with families (Sparks, 2020), while others eliminated family visits with no known increases in other types of communication (Sledge, 2020). The combination of solitary confinement and lack of family contact increases the likelihood that youth will experience significant trauma that can have long-term negative effects.

JCF staffing concerns provide another hurdle in the provision of emotional support to incarcerated and isolated youth during COVID-19. Similar to front-line medical staff and staff that work in other residential settings, JCF workers are at significant risk for experiencing burnout, fear and anxiety of contracting and spreading the virus (Neto et al., 2020). No information is available on JCF policies and practices designed to mitigate the risk of staff contracting and spreading COVID-19. Further, there is a complete lack of information concerning any training provided to ensure the physical safety of youth and staff or how to respond to the mental health needs of youth in this time of crisis.

Limited information also exists indicating that staff shortages in JCF have put youth at risk for harm. At times, the shortages have caused a reliance on unqualified staff, leading to unnecessary uses of force. In one facility, there were so many staff out, that probation officers were used. With no training, they resorted to the use of pepper spray to control youth (Sledge, 2020). However, the lack of transparency into how JCF are addressing staffing issues makes it difficult to be certain how widespread such problems are or to understand the effective approaches being implemented to ensure an adequate number of appropriately trained staff.

To understand JCF policies and practices during COVID-19 and chart a path forward, survey research is needed concerning approaches to, (a) ensuring youth and staff physical health,

(b) providing youth with social and emotional support, (c) delivering educational services, and (d) providing COVID-19 related information to youth, staff, and families. Interview research would also provide in-depth insight into youth and staff views and experiences during the crisis.

Important practices should be implemented immediately to ensure youth are educated and rehabilitated outside of their individual cells during "non-sleeping" hours. JCFs should adhere to the U.S. Centers for Disease Control and Prevention (CDC; 2020) guidance for correctional and detention facilities. The report also provides recommendations for structuring safe family visitation. Youth must also have ongoing access

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to qualified mental health professionals. Finally, plans are needed to guarantee an adequate number of qualified staff and that staff are trained in approaches to safeguarding the safety and well-being of youth during the crisis.

Declaration of Competing Interests

The authors declare that they have no competing interests.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psychres.2020.113219.

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